

## REQUEST FOR LEVEL OF CARE

**Program Requested:** ☐ Nursing Facility ☐ Home and Community Based Services  
**Fax to: 1-800-413-3890** ☐ Unknown ☐ Modified

### Requestor Information

Date of Request: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Screen Requested By: \_\_\_\_\_  
Agency: \_\_\_\_\_

### Applicant Information

Individual's Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Physical Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
County of Application: \_\_\_\_\_  
D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Veteran: ☐ Yes ☐ No  
Medicaid Status: \_\_\_\_\_  
Residential Status: (i.e., home, nursing facility, retirement home) \_\_\_\_\_  
Name of Facility: \_\_\_\_\_  
Nursing Facility Admit Date: \_\_\_\_\_ Anticipated LOS: \_\_\_\_\_  
Medicare Skilled? \_\_\_\_\_ Date \_\_\_\_\_  
Previous Medicaid Screen? \_\_\_\_\_ Date \_\_\_\_\_  
Health Care Professional: \_\_\_\_\_ Phone: \_\_\_\_\_

### Contact Information

#### Primary Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
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Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

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Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

**Dementia:** ☒ Yes ☐ No **Traumatic Brain Injury:** ☒ Yes ☐ No **Communication Deficit:** ☒ Yes ☐ No

### Comments